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(e) The facility specific percentage shall be determined by summing 40 percent of the statewide percentage and 60 percent of the corresponding regional percentage determined pursuant to clause (d) of this subparagraph.

(ii) The adjustment to the rate for a facility shall be determined by applying the facility specific percentage figure calculated in subparagraph (i) of this paragraph to a facility's adjusted base and added to the operating portion of the rate.

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-Reserved-

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(s) Adjustment of rates pursuant to methodology changes effective October 1, 1990 and April 1, 1991.

(1) Rate changes resulting from the [Amendments] amendments to sections 86-2.1(a), 86-2.9(c), 86-2.10(a)(3), (c)(1)-(5), (d)(1) & (2) and (p)(2)[,] and (3) [& (4)], and 86-2.30(c)(3) of this Title effective October 1, 1990, and amendments to sections 86-2.10(a)(3), (c)(1), (3) and (5), (d)(1), (2) and (4)-(7), (p)(1)-(3), and (t)(1) and (2) of this Title effective April 1, 1991 shall be [reflected in 1990 and 1991 rates pursuant to the following schedule] as follows:

(i) For rates with effective dates commencing between October 1, 1990 to [March 31, 1991] and June 30, 1992, [actual rate change shall not exceed 0 percent] the rate shall be computed using the rate methodology in effect on September 30, 1990, adjusted by the most recent PRI submissions applicable to the effective period of the rate, and the adjustment to the regional direct and indirect input price adjustment factors pursuant to subparagraph (iv) of paragraph (1) of subdivision (m) of this section.

(ii) [For rates with effective dates commencing between April 1, 1991 to June 30, 1991, actual rate change shall not exceed 2 percent.

(iii) For rates with effective dates commencing between July 1, 1991 to September 30, 1991, actual rate changes shall not exceed 4 percent.

(iv)] (ii) For rates with effective dates commencing on or after [October 1, 1991] July 1, 1992, the full impact of the [methodology] rate changes [effective on October 1, 1990] cited in paragraph (1) of this subdivision shall be reflected in rates.

(iii) Those facilities with an initial budgeted rate or revised cost-based rate which reflects a change in base year and which is effective after April 1, 1991, shall receive the full impact of the methodology changes cited in paragraph (1) of this subdivision on the effective date of such rate.

(2) For facilities having multiple rates based on levels of care prior to October 1, 1990, such rates shall be combined for the establishment of rates effective October 1, 1990 to [March 31, 1991] June 30, 1992 based on a weighted average of reproted Medicaid days for each previous level of care for the latest available cost reporting period. Where the Department is authorized expressly by statute to adjust rates retrospectively, for both positive and negative rate adjustments, such combined rate shall be adjusted by a reconciliation of reported Medicaid days to actual billed Medicaid days for the effective period, provided that such adjustment results in a combined direct and indirect component rate change of more than 5%. Such combined rate shall reflect the amendments referenced in paragraph (1) of this subdivision pursuant to the schedule set forth therein.

(3) Notwithstanding the provisions of paragraph (1) of this subdivision, residential health care facilities which have been identified by the Department as requiring registered nurse staffing increases to provide seven days a week, eight hours per day of day shift registered nurse coverage shall receive rate changes effective October 1, 1990 at a level sufficient to compensate

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facilities for additional expenses of expanding registered nurse coverage based upon a survey of costs to be incurred by affected facilities.

(4) Nothing within this subdivision shall preclude the Department from fully implementing rate adjustments on or after October 1, 1990, which are unrelated to methodology changes referenced in paragraph (1) of this subdivision.

(t) Base Year Adjustment for Facilities Who Have Bed Conversions.* A facility shall be eligible for an adjustment to its base year costs if its proportion of beds identified as skilled nursing facility beds and health related facility beds as of the first day of its base period differs from the proportion of beds identified as skilled nursing facility beds and health related facility beds as of September 30, 1990. The adjustment shall be separately determined for the direct, indirect, and non-comparable components of a facility's allowable base period costs, and each adjustment shall be added to a facility's allowable direct, indirect and non-comparable costs, respectively, prior to group comparisons. The amount of the adjustment shall be determined as follows:

(1) Base period direct, indirect, and non-comparable costs per bed adjusted for occupancy level shall be separately calculated for both skilled nursing and health related facility beds. The changes in skilled nursing and health related facility beds for the period defined in the above paragraph shall be multiplied by the applicable cost per bed and added together to arrive at each adjustment amount.

(2) An adjustment to allowable days shall also be made for a facility whose total number of beds has changed for the period described in this subdivision to reflect the skilled nursing facility and health related facility occupancy levels used in the [illegible]ation of rates effective September 30, 1990. Base period days shall be adjusted by the proportion of total new beds as of September 30, 1990 to total base year beds prior to the determination of the

* for rates effective July 1, 1992

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facility-specific price per day for the facility's direct, indirect, and non-comparable cost components.

(u) **Adjustment for Additional Federal Requirements.** A facility whose rate is based on allowable or budgeted costs for a period prior to April 1, 1991 shall be considered eligible to receive a per diem adjustment to its rate as follows:

(1) A per diem adjustment shall be incorporated into each facility's rate to take into account the additional reasonable costs incurred by facilities in complying with the requirements of subsection (b), (other tha paragraph 3(F) thereof), c), and (d) of section 1919 of the federal Social Security Act effective October 1, 1990 as added by the federal Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Additional reasonable costs resulting from such federal requirements shall include additional reasonabl costs in the following areas: the completion of resident assessments, the development and review of comprehensive care plans for residents, staff training for the new resident assessment tool, quality assurance committee costs, nurse aide registry costs, psychotropic drug reviews, and surety bor requirements.

(i) The per diem adjustment shall be forty-five cents computed on a statewide basis and shall be regionally adjusted to reflect differences in registered nurse salary levels for calendar year 1987. Any costs over the per diem adjustment shall be deemed attributable to factors other than compliance with the federal requirements referenced in this subdivision.

(ii) For purposes of inclusion in facility rates for 1991, the annual incremental per diem add-on shall be effective for the nine month period beginning April 1, 1991 and further adjusted so that the nine months of incremental cost are reflected in a per diem adjustment for July 1, 1991 through December 31, 1991 rates.

(2) For rates years beginning on or after January 1, 1992, the annual incremental per diem add-on calculated pursuant to subparagraph (i) of paragraph (1) shall be trended forward by the applicable facility trend factor.[1]

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[1] Trend factors are computed in accordance with Section 86-2.12 of this Plan.

Description of the Specific Methodology Used in Determining the Adjustment

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and comprehensive assessments, the additional cost pertains to completion of the MDS+[2] document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same as prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessmen of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or (.5) ((.45) + (.5)) = .48. The total number of assessments per bed would be 1 .48 = 1.48.

[2]MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

Based on a time study of the MDS[3], it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of $24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

(# assessments/bed) (# beds) (incremental time/assessment)

(1.48) (105,000) (.75) ($24) = $2,797,200 for comprehensive assessments

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

(2.2) (105,000) (.5) ($24) = $2,772,000 for quarterly assessments

[3]MDS (Minimum Data Set)

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Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received occupational therapy. Based on the new code requirements, it is estimated that twice this number, or 42% PT and 18% OT, will require additional care planning participation by these therapists For those residents requiring PT/OT services, an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of $31.50 for physical therapists and $30.00 for occupational therapists, the added cost would be $15.74 for PT and $15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activities worker care planning time for 100% of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were $24.00, for social workers $15.40, for dieticians $21.00, for activities workers $10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation is as follows:

(# plans/bed) (# beds for all residents) (incremental time for each discipline x hourly rate x percent of care plans involving discipline) = statewide cost

(1.48)(105,000) ((.5 x $24 x 100%) + (.5 x $15.40 x 100%) + (.5 x $21.00 x 100%) + (.5 x $10.00 x 100%) + (.5 x $31.50 x 42%) + (.5 x $30.00 x 18%))

$6,917,631

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Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of $6.00 per review was used:

(# care plans/bed) (# beds) (incremental cost/plan) = statewide cost

(2.2) (105,000) ($6.00) = $1,386,000

Training on MDS[4] Assessment

An estimate of 70,020 was used, based on the industry's estimate which was found acceptab.

Cost of training for up to 80 beds	$229,950
80 bed increments	$140,070
	$370,020

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[4]MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)